Arizona Basic Health Benefit Plan: A Comprehensive Review

Arizona Health Care Cost Containment System

July 2001

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Executive Summary

Benefit plan design is one of the key determinants of the level of participation in any health insurance program. It is, therefore, critical for policy-makers to consider the key variables of benefit plan design to meet the needs of the uninsured.

William M. Mercer, Incorporated (Mercer) has produced this briefing paper for the Arizona Health Care Cost Containment System (AHCCCS) as part of the Arizona State Planning Grant, which is funded by the Health Resources and Services Administration (HRSA). It is important to note that this is one in a series of papers provided as a tool for policy makers as part of the HRSA grant process to develop strategies to increase access to health care in Arizona. The Statewide Health Care Insurance Plan Task Force (Task Force) will be placed with the responsibility of developing plans for providing Arizona uninsured populations with affordable, accessible health insurance.

As part of the HRSA grant, an informal, ad-hoc subcommittee of the Task Force has proposed a preliminary Basic Health Benefit Plan (Proposed Plan) as a starting point for the complete Task Force. The Proposed Plan is roughly based upon the Arizona Basic Health Benefit Plan (ABHBP). The final benefit plan, including covered services, cost-sharing measures, and premiums will be determined by the full Task Force. This paper is a review of the Proposed Plan and primarily focuses on the Proposed Plan's appropriateness for Arizona's uninsured population. Because the Proposed Plan lacks sufficient detail for a thorough analysis, the ABHBP was used for comparative purposes. Appendices 1 and 2 contain summaries of the Proposed Plan and the ABHBP, respectively.

This paper begins with a summary of general insurance coverage considerations, including the different forms of insurance, benefit design variables, and overall affordability. This is followed by a brief summary of the Proposed Plan in the context of the previously outlined coverage considerations. Other states' initiatives to expand insurance coverage to the uninsured are also discussed to provide a comparison to Arizona's effort. Finally, the Proposed Plan's specific design elements are examined from the viewpoint of the uninsured. Throughout this paper, the following three coverage considerations will be utilized as a framework for reviewing the Proposed Plan.

Forms of Insurance

Health care insurance takes three major forms: catastrophic, indemnity, and pre-paid. The truest form, catastrophic insurance, most closely meets the original goal of insurance—protection of assets from disastrous loss. Indemnity insurance typically features an initial deductible followed by coinsurance. Various levels of deductibles and coinsurance are available to tailor the level of coverage to individual needs. Pre-paid insurance provides preventive services in an attempt to avoid or mitigate more expensive health care later.

Each of these forms of insurance appeals to individuals with very different needs. The Proposed Plan and the ABHBP focus on indemnity and pre-paid insurance.

Benefit Design Variables

There are three basic design variables that must be considered when creating a benefit plan: covered services, benefit levels, and cost-sharing provisions. Covered services determine what services an insurer will pay for, while benefit levels determine how much the insurer will pay. Cost-sharing provisions are payments in addition to the premium and generally include deductibles, coinsurance, copays, and/or out-of-pocket limits. A benefit plan's unique combination of these elements, combined with the premium payment, establish the insurance plan's appeal and affordability.

Overall Affordability

The question of whether or not to purchase health insurance is essentially an economic one—Will I be better off financially with or without health insurance? For much of the middle class, who desire to protect their hard-earned assets, the answer is to insure. For them, the risk of losing those assets because of a large medical claim outweighs the cost of the insurance. For the very wealthy, health insurance is not as important, since they have more than sufficient resources to cover even large health care claims. Still, this group may purchase coverage if they see it as financially advantageous. Lower income persons, with minimal assets to protect, may make the very rational decision to use their limited financial resources for other basic needs that are more immediate and certain, such as housing, clothing, and food.

The average deductible provided by very large employers (500+ employees) in the Southwest region is $200 for individuals and $250 for families. If deductible levels offered under the Proposed Plan exceed these levels, they may become financially unmanageable for the uninsured. The proposed coinsurance benefit of 80% is in line with those offered by employer-sponsored health plans. The health maintenance organization (HMO) copays should be relatively small ($5 to $10) so that they do not become a barrier to care for lower-income uninsured. Out-of-pocket limits should be determined by considering the expected income of the uninsured population. The recommended out-of-pocket limits in the Proposed Plan allow for more than 14% of a family's income to be spent on
out-of-pocket health care costs (assumes a family of 3 making 200% federal poverty limit (FPL)). When these out-of-pocket expenses are combined with premium payments, the total cost exposure to many uninsured will likely be considered excessive.

According to a recent survey (1), 74% of the uninsured state that their primary reason for not buying insurance is high cost. If premium levels of the Proposed Plan are set equal to the average cost of insurance available on the small group market, a price generally available to the uninsured population already, then the program will likely not be

effective in meeting the financial needs of the uninsured. Most reasonably comprehensive benefit designs will not be affordable to Low-Income Uninsureds without the use of significant subsidies by employers, state agencies, or other sources.

Methodology

The Arizona Health Care Cost Containment System (AHCCCS) Administration has secured a grant from the Health Resources and Services Administration (HRSA) to answer fundamental questions regarding the uninsured in Arizona. Several factors and characteristics affect the uninsured, although they are not uniform across all populations. It is important to note that as key groups of the uninsured are identified, different solutions will surface for different populations throughout Arizona.

In addition to this paper, AHCCCS has requested the presentation of six other policy issues papers. The seven policy papers are the following:

- Identification of Sub-Populations,
- Strategies to Improve Rural Access to Health Care,
- Critique of Proposed Basic Benefit Package,
- Incentives to Increase Health Coverage,
- State High-Risk Pools,
- Purchasing Pools, and
- International Health Care Delivery Systems.

To develop our findings for the three papers, Mercer conducted an electronic search for studies, articles, and materials on the uninsured. Mercer's internal electronic research services, the Washington Resource Group (WRG) and the Information Research Center (IRC), were utilized in obtaining materials describing the uninsured. Numerous Web sites were researched with the most comprehensive listed below:

- The Commonwealth Fund, www.cmwf.org;
- The Kaiser Family Foundation, www.kff.org;
- Medlineplus, www.medlineplus.gov;
- Employee Benefit Research Institute, www.ebri.org;
- Robert Wood Johnson Foundation, www.rwjf.org;
- National Academy for State Health Policy (NASHP), www.nashp.org; and
- State Coverage Initiatives www.statecoverage.net.

To provide the state-specific comparisons, Mercer either contacted the state programs directly or the Mercer office responsible for employer-sponsored health coverage for that state.

Coverage Considerations

Within the last hundred years, medical science has progressed from essentially home remedies to advanced technologies, such as molecular biology. While these advances have increased the quality and duration of life, they have not come without a price. It is the high and often unpredictable nature of medical costs that has led to the creation of health care insurance.

As with other forms of insurance, health care insurance is generally accepted as a financing vehicle, not a funding source. Insurance allows those seeking financial protection from a *potential* financial loss to pool their resources with similarly situated individuals. An individual can then receive funds from the pool at the time of loss. The level of funding required for any one individual or family is a function of the amount of potential loss and the probability of the loss occurring. Insurance by itself does not create additional sources of funding outside the pool. Therefore, an insured individual still pays for his *expected* health care costs out of his own pocket. However, the individual escapes the possibility of financial ruin through the insurance's ability to average the expected cost across similarly situated individuals.

The concept of insurance works because, while everyone is at risk of needing health care services, not everyone will need them at the same time (if at all) or need them to the same degree. A rule of thumb in the insurance market is that 80% of all health care costs are generated by only 20% of those insured. Thus, some people receive far more than what was contributed on their behalf, while others receive far less.

To be successful in achieving their goal of appealing to a large target market, designers of insurance policies must carefully consider several key design elements. Among these are the forms of coverage, the benefit package design, and overall affordability. Each of these is discussed in more detail below.

Forms of Insurance

Several forms of insurance coverage have evolved to address the individual needs of the purchaser. It is important to understand these types of insurance so that programs and services can be tailored to the special needs of targeted populations. There are three basic forms of health care insurance that will be focussed on in this paper: catastrophic, indemnity, and pre-paid. Each of these provides different levels of financial protection and meets different individual's needs for security. Additional forms of coverage, such as specialty policies, true indemnity policies, Medical Savings Accounts, etc., will not be discussed in this paper since they do not directly relate to the Proposed Plan.

Catastrophic Insurance

The most basic form of insurance is the coverage of catastrophic claims. Catastrophic insurance is sometimes referred to as "true" insurance because its job is to protect from a loss that would result in financial ruin. The very concept of insurance grew out of a need to provide financial protection from cataclysmic events, such as the loss of a ship's cargo at sea. Eventually, this concept was applied to health care costs. Original forms of health care insurance were designed to protect an individual from the catastrophic financial loss associated with a hospital stay.

Today's catastrophic health insurance policies cover claims arising from a comprehensive list of health care services. However, as a policy of insurance against health care loss, catastrophic insurance typically covers only claims associated with illness or injury. Preventive services, such as annual check-ups, vaccinations, pap smears, or routine mammographies, are generally not covered. In any case, these "well-care" services would be unlikely to break through a catastrophic policy's deductible level and trigger a benefit payment.

Case Study (Catastrophic)

The following case study uses a fictitious family (Sam, Holly, and their child Nicki) with an income of 200% of the FPL to illustrate the level of protection afforded by different forms of insurance.

Sam and Holly have purchased catastrophic insurance in the form of a $3,000 high deductible policy at an annual premium of $1,200. Benefits of 100% of covered services begin after $3,000 in eligible expenses has been incurred per insured.

The table below illustrates costs associated with good health as compared to costs associated with a $200,000 large claim on Holly.

	Good Health	Large Claim
Insurance Cost	$1,200	$1,200
Sam	0	0
Holly	250	3,250
Nicki	350	350
Total	$1,800	$4,800
% of total annual income ($28,000)	6.4%	17.1%

Assuming that Sam and Holly's health care costs go as planned, their total outlay for medical costs for the year will equal $1,800. If they had decided not to purchase any insurance at all, their health care costs would only be $600, or 2.1% of annual income.

However, if Sam or Holly suffer a large claim, because they have purchased a catastrophic policy, their cost for the claim is limited to $3,000. Total health care outlays for the year increase to $4,800.

Catastrophic policies are most popular with those of middle and higher incomes seeking protection from unexpected medical costs. They value the financial protection offered from unexpected high medical cost. While within the financial reach of many lower income individuals, these individuals do not place as high a value on catastrophic insurance because they have fewer financial assets to protect in the event of a large unexpected medical claim. Thus, of the four major sub-populations of the uninsured previously identified, only the higher income individuals within the working and Rural Uninsured groups would be likely to purchase catastrophic insurance.

Summary of Catastrophic Insurance

Below is a brief summary of the strengths and weaknesses of catastrophic insurance, followed by a table evaluating the success of a typical catastrophic insurance program in meeting the needs of certain uninsured sub-populations. Success is measured by comparing the strengths and weaknesses of the form of insurance as it relates to the specific sub-populations. Examples of measures used to determine success would include the comprehensiveness of the covered services, access to providers, and affordability to the uninsured individual. The specific uninsured sub-populations used throughout this document are described in detail in Mercer's paper completed for AHCCCS and the Task Force, titled "Faces of the Uninsured."

Strengths

- Protection from financial ruin
- Lack of restrictions on providers
- Provides protection only when truly needed, when a large medical claim threatens financial catastrophe
- Lowest cost premium for this type of protection
- Coverage can be tailored to specific medical services, such as hospitalization and surgery

Weaknesses

- Limited coverage for acute care services
- Preventive services not covered
- Does not compare well to policies typically provided by employers
- Lower income uninsureds find policy offers little in terms of real financial protection

Evaluation of Success of Catastrophic Insurance

	Minimal Success	Moderate Success	Successful
Low-Income Uninsured	✓		
Ethnic Uninsured	✓		
Working Uninsured		✓	
Rural Uninsured		✓	

Indemnity Insurance

In an effort to control the rising costs of health care insurance, the concept of indemnity insurance became popular. Unlike catastrophic policies, which pay benefits only after a disastrous loss occurs, indemnity policies begin paying at much lower levels of loss, supplementing the insured's payments. The conventional indemnity insurance plan is often referred to as a comprehensive major medical policy. A variation of this plan is the Preferred Provider Organization (PPO), which combines the deductibles and coinsurance of an indemnity plan with the negotiated discounts of a pre-paid plan. These policies typically feature an annual deductible and cost-sharing in the form of coinsurance, with PPOs featuring larger deductibles and reduced coinsurance levels for services obtained outside the PPO network. The indemnity insurance policy was designed to slow the growth of health insurance through cost-sharing mechanisms with the insured, while concurrently providing complete health care coverage.

Indemnity insurance policies provide fairly comprehensive coverage of a wide range of medical services from hospital stays to outpatient services to physician services, and often, prescription drugs. However, most of these policies adopted the historical view of insurance as protecting against an unexpected loss. Therefore, preventive services, such as vaccinations, pap smears, and the like, were not originally covered. More recently, however, in an effort to compete with pre-paid plans, these policies have incorporated many well-care and preventive benefits.

Case Study (Indemnity)

Assume Sam's employer offers an indemnity plan in the form of a comprehensive major medical policy. This policy contains a $200 deductible per individual with a limit of two deductibles per year. After meeting the deductible, coinsurance equal to 80% of the health care costs kicks in up to a maximum cost to Sam and Holly of $2,500 (maximum out-of-pocket cost) per individual. The cost of this coverage is $4,800 per year for the entire family.

Assuming that Sam and Holly incur only their expected level of health care costs ($0 for Sam, $250 for Holly, and $350 for Nicki) during the year, their total outlay for the year under both scenarios would equal:

	Good Health	Large Claim
Insurance Cost	$4,800	$4,800
Sam	0	0
Holly	250	1,410
Nicki	230	230
Total	$5,280	$6,440
% of total annual income ($28,000)	18.9%	23.0%

With good health, Holly will still pay for her well-care visit that is ineligible for reimbursement. For Nicki, they will have to pay the $200 deductible plus 20% of the remaining $150, or $230. Now, however, total health care costs have increased to 18.9% of annual income.

However, if Holly goes into the hospital for a six-month stay, the policy affords them some protection against financial ruin. Total costs for Holly would include the $200 deductible plus 20% of the next $4,800, and the $250 well-care visit that is not covered. Total health care costs have increased again, however, to 23.0% of annual income.

Variable cost-sharing features (higher or lower deductibles and out-of-pocket maximums) typically available under an indemnity insurance policy, allow an individual or family to tailor their annual medical costs to their household budget, while providing a significant degree of financial protection. These policies with variable cost-sharing features are typical of those offered by employers to their employees, as well as individual policies. However, such policies are generally significantly more expensive due to higher annual premiums than catastrophic policies. This limits the market to those of middle and higher incomes. Lower income individuals and families tend to find the premiums and cost-sharing features prohibitively expensive. Households in rural areas find these policies more beneficial than households in urban settings primarily due to the lack of a viable pre-paid option in rural areas.

Summary of Indemnity Insurance Plan

Below is a brief summary of the strengths and weaknesses of indemnity plans, followed by a table evaluating the success of a typical indemnity insurance plan in meeting the needs of specified uninsured population.

Strengths

- Lack of restrictions on providers (except under the PPO option)
- Relatively low level at which benefits begin

- Availability under employer-sponsored benefit plans
- Reduced premium costs and easy access to physicians (under a PPO option)
- Available to individuals and families in rural areas when a viable pre-paid network is unavailable

Weaknesses

- Fewer utilization management techniques
- Lower income individuals and families have a harder time affording the high premiums and deductibles and coinsurance requirements
- Due to cost-sharing provisions, expenditures on health care are not always predictable

Evaluation of Success of Indemnity Insurance Plan

	Minimal Success	Moderate Success	Successful
Low-Income Uninsured	✓		
Ethnic Uninsured	✓		
Working Uninsured		✓	
Rural Uninsured			✓

Pre-paid Insurance

As health care costs continued to increase, a new financing mechanism was needed in order to rein in health insurance costs. Pre-paid health care, in the form of HMOs and some types of PPOs, gained popularity as the way to provide both comprehensive health care benefits and contain costs. Most pre-paid insurance policies feature negotiated provider discounts, coverage of preventive and well-care services, and utilization management to control unnecessary expenditures. While not a new concept, the use of HMOs was quickly adopted by employers in the mid 1980s as the primary health care delivery system for employees.

Unlike catastrophic and indemnity insurance plan, which provide financial protection to the insured only after a loss is suffered, pre-paid insurance took the position of providing preventive services as a way of avoiding or mitigating the higher costs associated with treating an illness. Instead of reimbursing an insured for services rendered, HMOs treat health care services as "pre-paid" and require only a small (usually between $5 and $20) copay to access services. In addition, HMOs often offer access to a myriad of quasi-medical services, such as weight loss clinics or smoking cessation programs. However, access to medical services is limited to those hospitals, physicians, and other providers under contract in an HMO's network. Low cost access to preventive and other services, together with aggressive provider contracting and utilization management practices, allows HMOs to offer very comprehensive benefit packages at premium costs often well below those of existing indemnity insurance plans.

Case Study (Pre-Paid)

Assume Sam and Holly decide to purchase the HMO coverage offered by Sam's employer. The HMO plan offers full coverage for physicians with a $10 copay and hospitals with a $200 copay. Well-care visits are also considered a coverage service. If Sam and Holly incur their expected health care, their total outlays for the year under both scenarios would equal:

	Good Health	Large Claim
Insurance Cost	$4,800	$4,800
Sam	10	10
Holly	10	210
Nicki	20	20
Total	$4,840	$5,040
% of total annual income ($28,000)	17.3%	18.0%

Since the copay is so inexpensive, Sam decides to go in for a check-up. Sam, Holly, and Nicki are able to pay copays for their physician visits, including the well-care visits. Even with Holly's large claim, her hospital copay is only $200. However, total health care costs are still nearly 18% of their annual income.

HMOs gained favor with employers, their employees, and individuals because of their reduced premium requirements and low out-of-pocket cost-sharing. In addition, the increased access to preventive services and the simplified billing practices were appealing. Families found that for a small copay, they could bring their children in for well-care check-ups, receive their vaccinations, or have their minor childhood illness treated. There was no paperwork to fill out afterward. Individuals with no or weak doctor-patient relationships also like the idea of an HMO. They probably would not need medical care anyway, but if they did, they now knew where to go to get it. Many senior citizens also embrace HMOs as a way to avoid all the headaches associated with complex insurance reimbursement forms and the availability of a prescription drug benefit.

Early on, the limitation on physician access was not seen as too great an obstacle to mitigate the increased benefits of HMO membership to most potential buyers except for some in the upper income categories. While not true in every case, generally upper middle and upper income groups did not embrace HMOs as readily as lower and middle income groups. Generally, upper income individuals were somewhat older, had established doctor-patient relationships (and were reluctant to give them up if their doctor was not in the HMO's network), and had sufficient income to more easily meet the deductible and coinsurance requirements of an indemnity or catastrophic insurance plan. Lower income individuals, especially those in jobs where their employer heavily subsidized the health care premium, flocked to HMOs for their affordable copays and low out-of-pocket expense. Individuals in rural areas; however, were essentially left out of the HMO revolution. Due to difficulties in developing rural networks, indemnity insurance plans still outnumber HMOs in rural areas today.

Summary of Pre-Paid Insurance

Below is a brief summary of the strengths and weaknesses of pre-paid insurance, followed by a table evaluating the success of a typical pre-paid insurance in meeting the needs of specified uninsured population.

Strengths

- Easy access to providers
- Low out-of-pocket costs, usually through copays
- Lower premium costs than conventional indemnity plan
- Less administration for consumer (no claim forms)
- Feeling of a medical "home" to go to when individuals need services
- Focus on preventive care

Weaknesses

- Limited provider panel
- Utilization management practices can be seen as controlling access to care
- Does not flourish in rural environments with a limited number of providers

Evaluation of Success of Pre-Paid Insurance

	Minimal Success	Moderate Success	Successful
Low-Income Uninsured		✓	
Ethnic Uninsured		✓	
Working Uninsured		✓	
Rural Uninsured	✓		

Benefit Design Variables

Within the three basic forms of health insurance, there are literally hundreds of options to choose from when designing a policy. The myriad of options can be grouped into three basic design variables: covered services, benefit levels, and cost-sharing provisions.

Covered Services

Covered services are medical services eligible for reimbursement or direct payment from the insurer. These can vary greatly from covering inpatient hospital charges only to covering a comprehensive list of medical and quasi-medical services. Typically, today's insurance policies cover a comprehensive list of services, including inpatient hospital, outpatient hospital, emergency room visits, surgery, primary care physicians, specialty care physicians, diagnostic lab and X-ray services, and prescription drugs. Other services,

such as experimental procedures, some preventive services, and services provided by certain provider types, are specifically excluded. However, many preventive and well-care services, such as pap smears, mammographies, well-child check-ups, and vaccinations, are covered under today's policies.

Of these covered services, inpatient hospital services are generally the most expensive and the primary reason for which health insurance has historically been sought. A typical stay in a hospital can cost $800 or more per day. Ancillary services and attending physician's fees can drive this cost up even further. Other services, such as outpatient surgeries, emergency room visits, and certain specialty care procedures, can also be very expensive.

Notable for its revolutionary approach to determining what services would be covered, the Oregon Health Plan (Medicaid) developed a list of covered services based on that service's efficacy in the treatment of a medical condition. Using a fairly complex decision model, Oregon added or removed medical services based on their ability to affect the health status for the greatest number of covered members within a given budget. Oregon will soon establish the Oregon Health Plan Standard, a second benefit plan, even more basic than the current plan. Oregon's approach marks a significant change in determining what services are covered, but has not been duplicated elsewhere.

Benefit Levels

Benefit levels are not synonymous with covered services. Covered services determine *if* the insurer will pay, while benefit levels determine *how much* they will pay. Health insurance policies benefit levels vary greatly and cause much confusion among the insured population. Benefit levels are governed by the policy's contractual language and are generally expressed in terms of reasonable and customary charges or contracted rates.

Most indemnity and catastrophic insurance plans tend to express benefit levels in terms of reasonable and customary charges. These policies will reimburse incurred expenses up to a maximum payment as defined by the reasonable and customary charge normally associated with that given procedure. Often, these policies limit the reasonable and customary maximum to no more than the 80th or 90th percentile. However, because the provider is generally not contractually obligated to accept the insurer's reasonable and customary payment level, they can seek any shortfall in their fee directly from the insured.

Pre-paid insurance contractually limits the payment made to the provider and removes the insured from the transaction. These contracted limits are negotiated individually or collectively with providers or provider groups. Most HMO contracts do not allow the provider to seek additional payment from the insured if their actual fee exceeds the contracted payment. However, services received from a provider outside the HMO's network are not covered at all and the insured is fully responsible for payment.

Health benefits are usually limited to a maximum dollar amount stated in the insurance policy's contract. These are generally referred to as lifetime maximum benefit limits, and virtually all insurance policies contain them in some form or another.

Cost-Sharing Provisions

Cost-sharing provisions work hand-in-hand with benefit levels to determine the amount of reimbursement or financial benefit an insured will receive from an insurance policy. Cost-sharing provisions take several forms. The four primary means of cost-sharing are: deductibles, coinsurance, copays, and out-of-pocket limits.

Deductibles

A deductible is a common feature of catastrophic and indemnity insurance plans. Deductibles are amounts an insurance policy requires to be expended by the insured prior to the payment of any insurance benefits. Deductibles are generally applied on an annual per person basis (each person insured under the plan must meet their own deductible level within a given year) and are set at a level high enough to avoid triggering insurance payments for minor routine care.

Coinsurance

Coinsurance is another common feature of indemnity insurance plans. After an insured meets the policy's deductible, the policy's coinsurance provisions kick in. Through coinsurance, the insurance company pays a certain percent, generally around 80%, of covered medical services. The insured pays for the remaining amount. In this way, the insured receives some financial assistance with larger medical claims, while still staying involved in the cost, and hopefully, management of the claim. The insured continues to pay a portion of the claims cost until a maximum out-of-pocket amount has been reached. Once the insured has made payments up to this point, the policy's stop-loss provision takes effect and usually pays 100% of the claim's allowable expenses up to the policy's maximum limits.

Some catastrophic insurance policies will pay 100% coverage once the deductible is reached. Others will use coinsurance to pay a portion of the allowable health care costs to some pre-defined limit before full coverage is provided.

Copays

Pre-paid insurance generally uses copays as their means of achieving cost-sharing with the insured. Lately, some indemnity policies have introduced copays for specified services, such as prescription drugs or office visits. A copay consists of a cash payment made by the insured directly to the provider at the time the service is rendered. The primary purpose of a copay is to discourage the inappropriate use of services, while still encouraging access to physicians. This represents a major shift in philosophy away from the deductible's primary purpose of preventing the triggering of insurance benefits for

minor routine care. Copays are consistent with an HMO's viewpoint of providing an insured timely, preventive care to avoid more costly care.

Out-of-Pocket Limits

An out-of-pocket limit establishes a maximum dollar amount that an individual will need to pay the insurance company. Premium payments are not considered part of the out-of-pocket expenditures. Instead, deductibles, coinsurance, and/or copays contribute to the out-of-pocket limit. Once this dollar limit has been reached, the insured individual will no longer need to pay the deductible or coinsurance amounts included in the out-of-pocket limit.

Overall Affordability

In order to participate in an insurance pool, it is necessary to contribute towards that pool. These contributions typically consist of monthly payments to the insurance company in the form of premiums. A premium is based on the anticipated average cost of an individual or family based on the medical history of similarly situated people. Premium levels also vary based upon the form of coverage, as well as the overall benefit package.

The requirement of premium payments introduces the concept of affordability. The overall cost of insurance is especially important in examining participation rates. There are three main issues related to affordability that must be considered when designing an insurance program:

1) ability to pay,
2) asset protection, and
3) risk adversity.

Ability to Pay

Seventy-four percent of the uninsured responded that they do not buy health insurance because it is too expensive [1]. As illustrated through the case studies presented above for someone at 200% of FPL, the typical premium for a family of 3 can cost 17% or more of their annual income. Add to this the cost of deductibles and coinsurance and the total costs for health care can exceed 20% of this family's income. At these levels, ability to pay becomes a real issue as the cost of housing, food, and clothing generally are perceived as more pressing needs.

One common way to increase the affordability of insurance is to subsidize their premium payment. Under employer-sponsored health care programs, an employer may, though is not required to, make a financial contribution towards an employee's health care insurance in order to encourage participation in the program. This contribution can range from as low as $1 to as much as the full cost of the premium. Generally, the employer makes some sort of significant contribution for an employee's coverage and somewhat

less for the employee's dependents or family coverage. In other cases, government or non-profit agencies will subsidize the premium amounts required to participate.

Asset Protection

Lower income individuals and families also tend to have fewer assets in need of financial protection. Since the basic concept of insurance is to provide protection of one's assets, the lack of any significant assets considerably diminishes the need to purchase insurance.

Risk Adversity

On average, the uninsured tends to be younger people in lower paying jobs. These younger people tend to be healthier and have a less perceived need for health care. Without a significant subsidy in the form of an employer contribution or government assistance, it should come as no surprise that these young uninsured people tend to decline insurance coverage, even when it is available to them.

One of the key factors that has allowed employer-sponsored health insurance to remain successful for so long is that the employer generally contributes the majority (typically 75%) of the employees' cost of coverage. With this level of support, even relatively young and healthy employees tend to find health insurance a "good deal" and agree to participate. Employees who are not offered this level of assistance often go uninsured. This self-selection process adversely affects the cost of insurance for the remaining pool of insured individuals. Only those most likely to need health care services are left to participate, causing the premiums to increase.

Designers of insurance programs must be aware of these phenomena to avoid inadvertently creating a program that targets too few individuals and, thus, drives up the cost for the others.

Arizona Proposed Plan

This section contains a brief description of the Proposed Plan recommended by the informal sub-committee of the Task Force. Appendix 1 contains a more comprehensive description of the Proposed Plan.

Forms of Insurance

As discussed in the Coverage Considerations section, starting on page 3, there are several forms of health care coverage. Services of the Proposed Plan may be provided through three distinct forms including:

1) indemnity plan,
2) indemnity plan with a preferred provider network (PPO), and
3) health care services organization (traditionally identified as an HMO).

The proposed indemnity plans include features from both the catastrophic and indemnity forms of coverage, while the health care services organization is comparable to a typical pre-paid coverage model.

Benefit Design Variables

The benefit design of the Proposed Plan is outlined in the following table:

Description	
Covered Services	Hospital, physician, emergency room (ER), pharmacy, ambulance, limited preventive services, other
Excluded Services	Dental, vision, mental health/behavioral health
Benefit Levels	$1 million lifetime maximum for indemnity plans
Cost-Sharing Provisions	
Deductible (indemnity only)	Not specified; ABHBP specifies $1,000 for individual or $2,000 for family
Coinsurance (indemnity only)	80% after deductible is met
Copay (HMO only)	Not specified; ABHBP specifies $500 per inpatient admission; $100 per outpatient visit; $35 for urgent care; $50 for ER; $5 for immunizations (same for indemnity); $20 for physician, pharmacy, and other
Out-of-Pocket Limits	Indemnity is $1,000 per individual and $2,000 per family, in addition to deductible and copays; HMO is 200% of annual premium for individual or family

Overall Affordability

Actual premium amounts have not been calculated for the Proposed Plan at this point. However, based upon the recommended forms of coverage and benefit design, the premiums are expected to be comparable to existing small employer indemnity and HMO plans that are currently available. Generally, indemnity plans have the highest premiums followed by indemnity PPOs and finally HMOs.

At this point, no subsidy of the individual's premium payment by employers and/or other sources, such as the state of Arizona, has been determined. Such subsidies are a key component of making premium payments for insurance affordable. Employers will have the opportunity to participate in the program; however, no employer contribution amount has been determined.

Other State Plans

Texas Health Pool Benefits

The following is a summary of the Texas Health Pool. More detailed information can be found on the Texas Health Pool Web site at www.txhealthpool.com.

Forms of Insurance

Services of the Texas Health Pool are provided through a PPO. The Pool utilizes BlueChoice Network as its PPO. Members may choose any medical provider or hospital; however, use of PPO providers ensures that the Plan will pay a greater coinsurance rate. If a member chooses non-PPO providers, the Plan will pay a lower coinsurance rate for covered services and there is no coinsurance maximum for covered expenses. In addition, members may choose from 1 of 3 Plans: I, II, III; each plan has different deductible amounts and out-of-pocket limits.

Benefit Design Variables

The benefit design of the Texas Health Pool is outlined in the following table: [2 and 3]

Description	
Covered Services	Hospital, physician, home health care, skilled nursing facility (SNF), hospice, pharmacy, behavioral health/substance abuse
Excluded Services	Dental, vision
Benefit Levels	$1 million lifetime maximum for each insured person; substance abuse lifetime maximum of $15,000; additional limits for behavioral health days, home health days, SNF days, hospice days
Cost-Sharing Provisions	
Deductible	Plan I—$500 Plan II—$1,000 Plan III—$2,500
Coinsurance	80% for PPO providers 60% for non-PPO providers
Copay	N/A
Out-of-Pocket Limits	Using PPO providers: ▪ Plan I—$2,500 ▪ Plan II—$4,000 ▪ Plan III—$10,000 No limits for using non-PPO providers

Overall Affordability

Monthly premiums vary based on area, age, gender, plan, and tobacco user category. Premiums range from $69 to $1,233 per month. Premiums decrease with higher deductibles and are higher for older age groups and tobacco use. Maximum out-of-pocket limits (includes deductible and coinsurance) for those using PPO providers range from $2,500 to $10,000 in the 3 Plans. For those using non-PPO providers, there is no maximum out-of-pocket limit.

Illinois Comprehensive Health Insurance Plan

The following is a summary of the Illinois Comprehensive Health Insurance Plan (ICHIP). More detailed information regarding ICHIP can be found at the State's Web site at www.state.il.us/ins/planalt.htm.

Forms of Insurance

Services of the ICHIP are provided through a PPO. There are 3 Plans:

- Plan 2 is a plan available to eligible persons under 65 who are enrolled in both Parts A and B of Medicare due to disability or end-stage renal disease. Medicare will be the primary payer.
- Plan 3 is a PPO plan available to eligible persons who qualify for traditional ICHIP under Section 7 and who are not eligible for Medicare.
- Plan 5 is a PPO plan available to federally eligible individuals who qualify under Section 15. There is no pre-existing condition limitation, and benefits for inpatient treatment of mental illness are limited to 45 days per calendar year for all hospitals.

Benefit Design Variables

The benefit design of the ICHIP is outlined in the following table: [4]

Description		
Covered Services	Hospital, physician, pharmacy, durable medical equipment (DME), ER, SNF, home health, hospice, behavioral health/substance abuse; maternity is also covered at an additional cost	
Excluded Services	Dental, vision	
Benefit Levels	$1 million lifetime maximum per individual; additional limits on SNF days, home health days, hospice days and behavioral health/substance abuse services	
Cost-Sharing Provisions		
Deductible	Individual Coverage Plans 2, 3, and 5: ▪ $500 ▪ $1,000 ▪ $1,500 ▪ $2,500	Family Coverage Plans 2, 3, and 5: ▪ $1,000 ▪ $2,000 ▪ $3,000 ▪ $5,000
Coinsurance	80% after deductible is met 60% if non-PPO providers are used (Plans 3 and 5)	
Copay	N/A	
Out-of-Pocket Limits	Individual Coverage Plans 2, 3, and 5:	Family Coverage Plans 2, 3, and 5:

Description		
	▪ $2,000 ▪ $2,500 ▪ $3,000 ▪ $4,000 ** Add $4,500 for covered non-PPO provider expenses for Plans 3 and 5	▪ $4,000 ▪ $5,000 ▪ $6,000 ▪ $8,000 ** Add $9,000 for covered non-PPO provider expenses for Plans 3 and 5

Overall Affordability

Premiums paid by persons insured by ICHIP averaged approximately $3,800 per year in 2000. Premiums vary by gender, age, geographic area, deductible amount ($500, $1,000, $1,500, or $2,500), and type of plan. Premiums are the same for Plans 3 and 5. Plan 2 has low premiums, since Medicare is the primary source of coverage.

Out-of-pocket limits include the deductible, coinsurance, and copay expenditures. In addition to the out-of-pocket limits shown in the table above, there will be a separate $300 deductible for each non-PPO hospital admission.

MinnesotaCare

The following is a summary of MinnesotaCare. More detailed information can be found on the MinnesotaCare Web site at www.dhs.state.mn.us/hlthcare/asstprog/mncare/default.htm.

Forms of Insurance

Services of MinnesotaCare are provided through a pre-paid arrangement by health care plans. There are four basic benefit sets for MinnesotaCare enrollees:

- Basic Benefit Set: Adults over 21 who are not pregnant and who are at or over 175% of the FPL;
- Expanded Benefit Set: Children up to age 21 and pregnant women;
- Basic Plus One Benefit Set: Adults 21 and older who are not parents and not pregnant and who are at or below 175% of the FPL;
- Basic Plus Two Benefit Set: Parents at or below 175% of the FPL.

Benefit Design Variables

The benefit design of MinnesotaCare is outlined in the following table: [5, 6, and 7]

Description	
Covered Services	Hospital, physician, dental, ER, hospice, home health, lab/x-ray, pharmacy, behavioral health/substance abuse, vision
Excluded Services	Private duty nursing, personal care attendant, non-preventive dental, nursing home, intermediate care facilities
Benefit Levels	Inpatient Hospital Benefit Limit ▪ Basic Benefit Set: $10,000 annual coverage limit and 10% copay for inpatient services ▪ Expanded Benefit Set: no annual coverage limit, no copays ▪ Basic Plus One Benefit Set: $10,000 annual coverage limit, 10% copay for services ▪ Basic Plus Two Benefit Set: no annual inpatient hospital coverage limit, 10% copay for services Additional limits on eye checkups and prescription eyeglasses and pharmacy.
Cost-Sharing Provisions	
Deductible	N/A
Coinsurance	N/A
Copay	▪ No copays for physician visits or outpatient hospital

Description	
	▪ Children under 21 & pregnant women: no copays ▪ Enrollees age 21 and older and not pregnant: 10% of inpatient hospital charges up to $1,000, $3 per prescription, and $25 for each pair of eyeglasses
Out-of-Pocket Limits	▪ No limits for children under 21 and pregnant women ▪ No limits for adults who have a child under 21 in their home and whose income is equal to or less than 175% of the FPL

Overall Affordability

Enrollees pay monthly premiums based on income, family size, and the number of individuals being covered. For example, a single adult who earns the maximum monthly income allowed to qualify of $1,202 pays $58 per month; the monthly income of $750 pays $31; the monthly income of $500 pays $9. A household of 3 making less than $709 per month before taxes pays $12 per month; the monthly income of $1,000 pays $18; the monthly income of $2,000 pays $96; and the maximum earning amount of $3,180 pays $280. In addition, there are no copays for children and pregnant women.

Kentucky Access

The following is a summary of the Kentucky Access program. More detailed information about the program can be found on the Kentucky Access Web site at www.onlinehealthplan.com/oasys/Kentucky/html/covered_benefits_guide.pdf.

Forms of Insurance

Services of the Kentucky Access program are provided through three plan designs:

- Traditional Access: traditional, indemnity type plan;
- Premier Access: PPO program; and
- Preferred Access: PPO program.

Benefit Design Variables

The benefit design of the Kentucky Access program is outlined in the following table: [8 and 9]

Description	
Covered Services	Physician, hospital, ER, DME, SNF, home health, hospice, pharmacy and behavioral health/substance abuse are covered at an additional cost
Excluded Services	Vision screening, dental, SNF are not covered for Preferred Access plan
Benefit Levels	▪ Traditional Access: no lifetime maximum ▪ Premier Access: $2 million lifetime maximum ▪ Preferred Access: $2 million lifetime maximum
Cost-Sharing Provisions	
Deductible	▪ Traditional Access: $400 individual, $800 family ▪ Premier Access: $400–$1,500 individual in-network; $800–$3,000 family in-network; $700–$2,250 individual non-network; $1,400–$4,500 family non-network ▪ Preferred Access: $750–$1,500 individual in-network; $1,500–$3,000 family in-network; $750–$1,500 individual non-network; $1,500–$3,000 family non-network
Coinsurance	Varies by service category, most services are 80% after calendar year deductible is met.
Copay	N/A
Out-of-Pocket Limits	▪ Traditional Access: $1,500 individual, $3,000 family ▪ Premier Access: $1,500–$4,000 individual in-network; $3,000–$8,000 family in-network; $2,500–$5,000 individual non-network;

Description	
	$5,000–$10,000 family non-network ▪ Preferred Access: $3,000–$5,000 individual in-network; $6,000–$10,000 family in-network; $3,000–$5,000 individual non-network; $6,000–$10,000 family non-network

Overall Affordability

Premium rates are based on age and sex. Annual premiums range from $296 to $984 for the Traditional Access plan; $124 to $806 for the Premier Access plan; and $123 to $698 for the Preferred Access plan. In addition, Kentucky Access offers several different payment cycles, including monthly, quarterly, semi-annual, and annual premium payment options.

Members may also purchase coverage for behavioral health/substance abuse and pharmacy. The behavioral health/substance abuse rider provides coverage for the Inpatient and outpatient treatment of mental illness provided to the same extent and degree as for the treatment of physical illness. Premiums for the behavioral health/substance abuse rider range from $102 to $492 for the Traditional Access plan; $62 to $403 for the Premier Access plan; and $61 to $348 for the Preferred Access plan. The pharmacy rider is subject to a $15 copay per prescription with certain coverage limitations. Premiums for the pharmacy rider range from $14 to $68 for the Traditional Access plan; $11 to $78 for the Premier Access plan; and $18 to $106 for the Preferred Access plan.

The out-of-pocket limits shown in the table do not include the deductible, coinsurance, or co-pay expenses for prescription drugs, any non-covered services, amounts charged for services in excess of the eligible expense, or amounts resulting from failure to comply with medical utilization management provisions or the plan delivery system rules.

Arizona Proposed Plan Critique

This section reviews the Proposed Plan by comparing it to the other state plans, typical small employer plans, and relying on Mercer's experience in the health care coverage market. The Proposed Plan has been reviewed from the perspective of the uninsured sub-populations in Arizona that were outlined in the paper completed for the Task Force, "Faces of the Uninsured."

After examination of these drivers, based on Arizona-specific information, several sub-populations for Arizona were identified. These sub-populations are large enough to merit a closer look, as they will help address the factors that cause people to be uninsured in Arizona.

The sub-populations and their key focal groups have been identified as:

Sub-population	**Focal Groups**
Low-Income Uninsured	Low-Income Uninsured Children and their Parents
Ethnic Uninsured	Low-Income Hispanic Uninsured
Working Uninsured	Working Uninsured in Small Employers
Rural Uninsured	Rural Low-Income Uninsured Children and their Parents

These groups are not mutually exclusive, and many individuals fall into more than one of these sub-populations. The Rural Health Office has been tasked with providing policy makers with additional insight into the non-duplicative sub-populations.

Several comparisons are made throughout this section to place the Proposed Plan in perspective for the Task Force. Where appropriate, expenses are compared to total income at 200% of the FPL for 2000 to determine what percent the expenses are of the total income. To be consistent with previous figures, the family unit comparison was based on a family unit of three.

Other benefit plan components were compared to the Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 2000. This study is the definitive annual study on the cost and features of employer-sponsored health plans in the United States. For comparison, we used the median plan feature for very large employers (defined as 500+ employees) in the Southwest (covering the states of Arizona, Colorado, Nevada, New Mexico, and Utah). For the Southwest region, the large employer data has the most statistical credibility and are weighted to be applicable to the entire region.

The outline of this section follows that of the previous sections by discussing the forms of coverage, benefit design, and affordability.

Forms of Insurance

The Proposed Plan recommends three separate forms of insurance coverage: indemnity, indemnity with PPO, and HMO. The following sections discuss some of the considerations related to these forms of coverage.

Multiple Forms of Insurance

The decision to offer more than one form of insurance coverage has many implications, both positive and negative. Individual participation will likely be better when more than one option is offered. Because the uninsured sub-populations have different needs and concerns, it is beneficial to include various forms of coverage. In addition, plan participation and competition will be increased as HMOs and indemnity plans contend for enrollment.

However, offering more than one form of coverage does have its drawbacks. The program is significantly more complex to administer. Likewise, more educational materials will need to be developed and distributed in order to aid individuals in choosing a specific form of coverage. Even with educational material, the complexity of the choices may lead to misunderstanding. Furthermore, the risk of the populations enrolling in the various forms of coverage may vary dramatically. This occurrence, often referred to as selection, can create significant imbalances between the indemnity, indemnity PPO, and HMO plans. These imbalances lead to higher premiums in certain plans and create concerns for insurance providers that are left with the highest cost individuals.

Of the other state plans reviewed in this paper, none of them included both an indemnity and HMO option. However, it was common for plans to include a typical indemnity and indemnity PPO plan together. Only 4 percent of small to large employers (0–99 and 100–499 employees) nationally offer both indemnity and managed care plans, while 18 percent offer multiple forms of managed care plans (e.g., HMO, PPO, Point of Service). These percentages are 17 percent and 36 percent respectively for very large employers (500+ employees) [10].

Rural Issues

As discussed in the Coverage Consideration section, an HMO model is often not feasible in rural areas. Due to relatively few health care providers and hospitals, HMOs need these providers and hospitals in their network, but are often unable to negotiate discounted rates due to the lack of competition among providers. Indemnity PPO plans have the same concern in rural areas, since they are dependent, in large part, on their network of providers. Thus, indemnity PPO and HMOs plans have tended to be reluctant to participate in rural areas. However, Arizona's Medicaid program, based upon an HMO coverage model, has been successful in extending managed care to the rural areas. These Medicaid managed care plans are currently participating in every Arizona county.

Coordination of Care

One drawback to the indemnity plans is that there is typically not an effort to coordinate an individual's health care among providers. Typical HMO and primary care case management (PCCM) programs require individuals to go through a "gatekeeper" before receiving specialty services. While often considered a hassle to the insured, this gatekeeper approach can save money and lead to a higher quality of care due to provider coordination. Likewise, a lack of coordination can lead to duplication of services and unnecessary treatments. Even if a gatekeeper model is not adopted, prior approval from a physician for certain services (e.g., specialty services) would lead to lower premiums and enhanced coordination of care. Of the states plans reviewed, only MinnesotaCare is based upon an HMO model and, therefore, includes a "gatekeeper" primary care physician.

Benefit Design Variables

Overall, the Proposed Plan benefits package is comparable to private commercial insurance available to small employers in the Arizona health care market. Specifics will be discussed under each subheading listed below:

- Covered Services—types of and any exclusions on the services included within the plan, clinical appropriateness of services, focus on preventive services;
- Benefit Levels—types of and any limitations on the reimbursement amounts; and
- Cost-Sharing Provisions—deductibles, coinsurance, copay, and out-of-pocket limits.

It is important to note that the ABHBP, from which the Proposed Plan was derived, by definition "…must contain benefit definitions, language, certificates of coverage, provider definitions, exclusions and limitations, and commission structures that are comparable to its most commonly used, or what is presumed to be its most commonly used, group health plan closest in size to the small employer group health plans currently being offered…" [11]. Thus, to the extent that the Proposed Plan will mirror the ABHBP in this regard, it will be comparable to similar benefit plans available in the small group marketplace.

Covered Services

The Covered Services section deals with the inclusion and exclusion of specific services in the benefit package. This section has been separated into three categories: basic services, clinical appropriateness, and preventive services.

Basic Services

As mentioned above, the covered services in the ABHBP and Proposed Plan are comparable to those available in the small group marketplace. As a result, the covered service package is quite comprehensive, including such key features as hospital inpatient, outpatient, physician, maternity, and pharmacy services. For the low income and Hispanic Uninsured, transportation can be problematic to and from medical services.

Medicaid addresses this by providing non-emergency medical transportation. This is not a covered service in the Proposed Plan, but may be appropriate with prior approval for low-income sub-populations. Other exclusions, such as vision, dental, and behavioral health/substance abuse services, will keep the premiums down, but will deter some individuals from enrolling in the Proposed Plan. Dental and vision services were excluded in three out of the four other state plans reviewed, whereas, behavioral health/substance abuse was included in all of the other state plans (although Kentucky Access included pharmacy and behavioral health/substance abuse as optional services for an additional fee). Finally, chiropractic services must be covered according to Arizona House Bill 2600.

As a general note, the description of the benefit package may be changed in order to highlight important inclusions, as well as exclusions. For example, therapies may be included, but specific types of therapy, such as physical, speech, and occupational therapy, or even cardiac and pulmonary rehabilitation, should be specifically mentioned. Also, some of the typical exceptions, such as birth control medication, blood products, diabetic monitoring equipment, and cosmetic surgery, should be addressed at some point. By improving the detail of the covered services, individuals (as well as interested insurance plans) will have fewer questions and concerns with the policy.

Exhibit 1. Evaluation of Success of Basic Services in Meeting Needs of Uninsured Sub-Populations

	Minimal Success	Moderate Success	Successful
Low-Income Uninsured		✓	
Ethnic Uninsured		✓	
Working Uninsured			✓
Rural Uninsured			✓

Preventive Services

Preventive services, including routine physical exams, immunizations, child well-care, and women well-care are included in the Proposed Plan. This is comparable to the other state programs, which all included some form of preventive coverage, including well child and immunizations. Kentucky Access has the most complete preventive service program, which includes adult care, maternity, and early detection services as well. MinnesotaCare was the only plan to include preventive dental care.

Although preventive services are covered in the Proposed Plan, at this point there is a lack of financial incentives designed to encourage participation in these preventive services. If the Proposed Plan follows the ABHBP, immunization will be the only preventive service identified in the indemnity insurance plan that will be based upon a minimal copay of $5 instead of a coinsurance amount. Other preventive services, including well-care, screenings, and prenatal visits do not include financial incentives to participate. Kentucky Access is a good example of a program with such financial incentives in place, including better coinsurance percentages for maternity and

immunizations and no deductible or coinsurance for well-care services. Examples of other benefit plans that are considered progressive in providing financial incentives for preventive services might include:

- Child Well-Care—100% after deductible or reduced copay;
- Woman Well-Care—100% after deductible or reduced copay;
- Physician Office Visits—Higher percentage coverage after deductible or lower copay for physician versus specialist;
- Prenatal Visits—100% after deductible or reduced copay; and
- Cancer and/or Diabetes Screenings—100% after deductible or reduced copay.

Exhibit 2. Evaluation of Success of Preventive Services in Meeting Needs of Uninsured Sub-Populations

	Minimal Success	Moderate Success	Successful
Low-Income Uninsured	✓		
Ethnic Uninsured	✓		
Working Uninsured	✓		
Rural Uninsured	✓		

Benefit Levels

At this point, the description of the Proposed Plan does not specifically address benefit levels, other than a maximum lifetime benefit. The indemnity insurance plans have a lifetime limit of $1,000,000, which is standard in the marketplace and the same as two of the four state programs reviewed. The HMO plan does not have a lifetime limit. Policy-makers often mandate some form of additional large cost insurance, known as reinsurance, when no lifetime limit is set. Based on the specific language linking the ABHBP to the most commonly used for small employer groups, Mercer has assumed the remaining benefit levels will be the same as those currently used as reasonable and customary levels in the small group marketplace. Overall, the benefit levels are considered to be moderately successful (see Exhibit 3).

Exhibit 3. Evaluation of Success of Benefit Levels in Meeting Needs of Uninsured Sub-Populations

	Minimal Success	Moderate Success	Successful
Low-Income Uninsured		✓	
Ethnic Uninsured		✓	
Working Uninsured		✓	
Rural Uninsured		✓	

Cost-Sharing Provisions

The following sections discuss the Proposed Plan's cost-sharing provisions in greater detail.

Deductibles

Deductibles are not specified in the Proposed Plan, so the ABHBP deductibles will be referred to in this section. Deductible levels are only applicable to the indemnity and indemnity PPO plans. The ABHBP includes deductibles ranging from $1,000 to $1,500 for individuals and $2,000 to $3,000 for families on an annual basis, depending upon whether the services are in- or out-of-network. For individuals, the $1,000 to $1,500 deductible represents a range of approximately 6% to 9% of the total income at 200% of the FPL. For a family unit of 3 with income at 200% of the FPL, the deductibles of $2,000 to $3,000 equal approximately 7% to 10% of the total income.

The deductibles, either in- or out-of-network, are substantially higher than the average of $200 and $250 for very large employers in the Southwest [10]. In general, they are in line with the other state plans, although the three state plans with deductibles offered several deductible and premium options ranging from $400 to $2,500. The size of the deductibles makes the indemnity insurance plan somewhat unattractive for those uninsured who tend to have a lower income (see Exhibit 4).

Exhibit 4. Evaluation of Success of Deductibles in Meeting Needs of Uninsured Sub-Populations

	Minimal Success	Moderate Success	Successful
Low-Income Uninsured	✓		
Ethnic Uninsured	✓		
Working Uninsured		✓	
Rural Uninsured		✓	

Coinsurance

The coinsurance percentages are only applicable to indemnity insurance plans. The Proposed Plan includes coinsurance percentages of 80% after the calendar year deductible has been satisfied for the in-network plan. The ABHBP uses 60% after the calendar year deductible has been satisfied for the out-of-network plan. This helps to promote the use of in-network services. These coinsurance percentages are the same as the other three state plans with coinsurance. The size of the remainder to be paid after the plan has paid makes the indemnity plans relatively unattractive to the Low-Income Uninsured (see Exhibit 5).

Exhibit 5. Evaluation of Success of Coinsurance in Meeting Needs of Uninsured Sub-Populations

	Minimal Success	Moderate Success	Successful
Low-Income Uninsured	✓		
Ethnic Uninsured		✓	
Working Uninsured			✓
Rural Uninsured			✓

Copays

Since the Proposed Plan does not include specific copays, we used the ABHBP copay amounts in this section. The copay amounts are only applicable to the HMO plan in the ABHBP, yet 30% of very large employers in the Southwest have begun to utilize copays for physician services in their indemnity insurance plans to hold down costs [10]. In addition, copays are commonly used in indemnity plans for pharmaceuticals to allow for management techniques. It is often beneficial to allow varying tiers of copays for the pharmacy line item to encourage the use of cheaper drugs. This is especially important in the HMO plan where there is no generic use requirement as there is in the indemnity plan.

Most services in the ABHBP have a $20 copay. This copay is higher than the average of $11 for very large employers in the Southwest in 2000 [10]. Copay amounts for the other states reviewed are also lower than the ABHBP copay amounts. Immunizations have a $5 copay for indemnity and HMO plans to encourage participation. Hospital and ER copays are on the high end of the spectrum, but reasonable. The most prevalent copay, $20 for physician services, would be considered prohibitive for Low-Income Uninsured (see Exhibit 6). A lower copay could still be effective in reducing unnecessary utilization for the Low-Income Uninsured.

Exhibit 6. Evaluation of Success of Copays in Meeting Needs of Uninsured Sub-Populations

	Minimal Success	Moderate Success	Successful
Low-Income Uninsured	✓		
Ethnic Uninsured		✓	
Working Uninsured			✓
Rural Uninsured			✓

Out-of-Pocket Limits

The out-of-pocket limits are $1,000 for individuals, and $2,000 for families, in addition to the calendar year deductible and copays. These out-of-pocket limits are approximately on par with the average for very large Southwest employers of $1,500 [10]. They are also in line with the other state programs, although the other state programs offer more than

one option for deductibles, premiums, and out-of-pocket limits. However, although comparable, only the uninsured populations that tend to be higher income, will be in a position to meet the out-of-pocket expenses associated with the indemnity insurance plans and the HMO plan (see Exhibit 7).

Exhibit 7. Evaluation of Success of Out-of-Pocket in Meeting Needs of Uninsured Sub-Populations

	Minimal Success	Moderate Success	Successful
Low-Income Uninsured	✓		
Ethnic Uninsured	✓		
Working Uninsured		✓	
Rural Uninsured		✓	

Overall Affordability

According to a Kaiser Family Foundation National Survey [1], 74% of the uninsured state that their primary reason for not buying insurance is high cost. Based upon the Proposed Plan benefit package, premium levels will not be significantly different than what is currently available on the small group market. Unless the premiums are heavily subsidized, it is unlikely that the program will meet the affordability needs of most uninsured. If deductible levels in the indemnity insurance plans and the copay amounts in the HMO plan are consistent with the ABHBP, they will contribute to the concern that overall the plan will not be affordable to most uninsured groups. The uninsured groups with the lowest income will not be able to pay for it, while many of those with higher incomes have already declined similar offers. According to one study, even if purchasing pools were more successful in lowering prices, subsidies would have to equal between one-third and one-half of the premium in order to produce a substantial reduction in the number of the uninsured [12].

Another concern is affordability over time. If enrollment is not significant, the risk pool will consist of only individuals with significant health care needs. This, in turn, will cause the premium to spiral upward causing the problem to exacerbate. For this reason, it is vital that the benefit package is affordable to as many of the uninsured sub-populations as possible (see Exhibit 8).

Exhibit 8. Evaluation of Success of Overall Affordability in Meeting Needs of Uninsured Sub-Populations

	Minimal Success	Moderate Success	Successful
Low-Income Uninsured	✓		
Ethnic Uninsured	✓		
Working Uninsured		✓	
Rural Uninsured		✓	

Other state programs have attempted to keep the cost down for certain sub-populations by varying premiums by age, gender, geographic region, income, and even tobacco use. MinnesotaCare varies the premium by the individual's percent of FPL. Such an approach allows for varying levels of subsidization for different income groups, but adds administrative complexity. Varying the premiums by age, gender, and geographic regions makes insurance more affordable to certain demographic sub-populations, but less affordable to other sub-populations.

Another approach utilized by state programs is to offer a variety of cost-sharing or service coverage options. For example, all three state plans with deductibles offered varying deductibles, premiums, and out-of-pocket limits. This allows individuals to choose whether they would like a lower premium, but higher deductible or visa versa. Another approach is to allow certain services to be covered as an add-on. Kentucky does not cover pharmacy or behavioral health/substance abuse as basic services, but if individuals desire coverage for these services, they can pay an additional premium amount and the services will be covered. Illinois does the same for maternity services. Again, this lowers the cost for certain sub-populations (e.g., non-pregnant individuals) at the expense of a higher premium for other sub-populations (e.g., pregnant women).

Appendix 1: Proposed Basic Health Benefit Plan (Proposed Plan)

Plan Features and Benefits		Indemnity Plan	Health Maintenance Organization
Calendar Year Deductible	Individual	(****)	Not Applicable
	Family Aggregate	(****)	Not Applicable
Physician Services	Office Visit	80% After Calendar Year Deductible	$** Copay
	Immunizations (Only)	Patient Pays Co-Payment	$** Copay
	Child Well-Care	80% After Calendar Year Deductible	$** Copay
	Woman Well-Care	80% After Calendar Year Deductible	$** Copay
	Maternity Services, including Prenatal/Postnatal Care, Labor and Delivery	80% After Calendar Year Deductible	$** Copay
	Diagnostic Lab and X-ray Services	80% After Calendar Year Deductible	$** Copay
Hospital Services	Inpatient Room and Board, Lab and X-ray Medical Supplies, and Miscellaneous Hospital Services	80% After Calendar Year Deductible (Pre-certification required)	$*** Copay Each Admission
	Outpatient Hospital	80% After Calendar Year Deductible	$*** Copay Per Visit
Emergency Care	Physicians Office	80% After Calendar Year Deductible	$** Copay
	Urgent Care Center	80% After Calendar Year Deductible	$** Copay
	Hospital	80% After Calendar Year Deductible	$** Copay (Waived if admitted)
	Ambulance	80% After Calendar Year Deductible	Covered at 100%
Prescriptions		80% After Calendar Year Deductible (Generic drugs when available)	$** Copay at a Participating Pharmacy
Out-of-Pocket		$1000 Per Individual,	Individual—200% Annual

Plan Features and Benefits		Indemnity Plan	Health Maintenance Organization
Limit		$2000 Per Family (In addition to calendar year deductible and copays)	Premium Family—200% Annual Premium
	Lifetime Maximum Benefit	$1,000,000 Per Individual	$****

Appendix 2: Arizona Basic Health Benefit Plan (ABHBP)

ABHBP may be provided through a commercial insurance carrier, a hospital and medical service corporation, or a health care services organization that has been approved as an Accountable Health Plan.

The benefits and services of ABHBP may be provided through an indemnity plan with or without a PPO or through the restricted provider network of a health care services organization (HMO).

ABHBP may be offered to any employer at any time.

****

ABHBP must include coverage for the following:

- Immediate coverage for children newly born, adopted or placed for adoption pursuant to A.R.S. §§ 20-826, 20-1057 or 20-1402.
- Continuing coverage beyond the limiting age for a child handicapped or disabled pursuant to A.R.S. §§ 20-826 or 20-1407.
- Benefits for surgical service, which is covered by the policy regardless of the place the surgery is performed pursuant to A.R.S. §§ 20-826, 20-1051 or 20-1402.
- Benefits for home health services prescribed in lieu of inpatient hospital care pursuant to A.R.S. §§ 20-826, 20-1051 or 20-1402.
- Benefits for diagnostic services performed outside a hospital in lieu of inpatient service pursuant to A.R.S. §§ 20-826, 20-1051 or 20-1402.
- Benefits for services performed in a hospital's outpatient department or in a freestanding surgical facility pursuant to A.R.S. §§ 20-826, 20-1051 or 20-1402.
- Benefits for breast reconstructive surgery and external postoperative prosthesis following a covered mastectomy pursuant to A.R.S. §§ 20-826, 20-1057 or 20-1402.
- Benefits for mammography screening pursuant to A.R.S. §§ 20-826, 20-1057 or 20-1402.
- Reimbursement for services within the lawful scope of practice of a registered nurse practitioner or a certified registered nurse qualified under the rules adopted by the State Board of Nursing pursuant to A.R.S. §§ 20-841.03 or 20-1406.03.
- Effective July 13, 1995, pursuant to A.R.S. § 20-2321 the Basic Health Benefit Plan also provides that the maternity benefits apply to the cost of the birth of a child who is legally adopted by the enrollee.

With respect to those benefits, ABHBP issued by an Accountable Health Plan must contain benefit definitions, language, certificates of coverage, provider definitions, exclusions and limitations, and commission structures that are comparable to its most

commonly used, or what is presumed to be its most commonly used, group health plan closest in size to the small employer group health plans currently being offered by that Accountable Health Plan in this state.

Attached is the schedule of benefits ABHBP.

11/95

Plan Features and Benefits		Indemnity Plan or Indemnity Plan in Preferred Provider Network	Indemnity Plan Out Of Preferred Provider Network	Health Maintenance Organization
Calendar Year Deductible	Individual	$1,000	$1,500	Not Applicable
	Family Aggregate	$2,000	$3,000 $500 Additional Per Hospital Admission (If pre-certification not received)	Not Applicable
Physician Services	Office Visit	80% After Calendar Year Deductible	60% After Calendar Year Deductible	$20 Copay
	Routine Physical Exams	Not Covered	Not Covered	$20 Copay
	Immunizations (Only)	Patient Pays $5 Copay	Not Covered	$5 Copay
	Child Well-Care	80% After Calendar Year Deductible	Not Covered	$20 Copay
	Woman Well-Care	80% After Calendar Year Deductible	Not Covered	$20 Copay
	Maternity Services, including Prenatal/Postnatal Care, Labor and Delivery	80% After Calendar Year Deductible	60% After Calendar Year Deductible	$20 Copay
	Allergy Testing and Treatment	80% After Calendar Year Deductible	60% After Calendar Year Deductible	$20 Copay
	Diagnostic Lab and X-ray Services	80% After Calendar Year Deductible	60% After Calendar Year Deductible	$20 Copay
	Vision Screening	Not Covered	Not Covered	$20 Copay
Hospital Services	Inpatient Room and Board, Lab & X-ray, Medical Supplies and Miscellaneous	80% After Calendar Year Deductible (Pre-certification required)	60% After Calendar Year Deductible (Pre-certification required)	$500 Copay Each Admission

Plan Features and Benefits		Indemnity Plan or Indemnity Plan in Preferred Provider Network	Indemnity Plan Out Of Preferred Provider Network	Health Maintenance Organization
	Hospital Services			
	Outpatient Hospital	80% After Calendar Year Deductible	60% After Calendar Year Deductible	$100 Copay Per Visit
Emergency Care	Physicians Office	80% After Calendar Year Deductible	80% After Calendar Year Deductible	$20 Copay
	Urgent Care Center	80% After Calendar Year Deductible	80% After Calendar Year Deductible	$35 Copay
	Hospital	80% After Calendar Year Deductible	80% After Calendar Year Deductible	$50 Copay (Waived if admitted)
	Ambulance	80% After Calendar Year Deductible	80% After Calendar Year Deductible	Covered at 100%
Prescriptions		80% After Calendar Year Deductible (Generic drugs when available)	60% After Calendar Year Deductible (Generic drugs when available)	$20 Copay at a Participating Pharmacy
Durable Medical Equipment		80% After Calendar Year Deductible	60% After Calendar Year Deductible	Covered at 100% (Limit of $2,000 per calendar year)
Mental Health and Substance Abuse Services	Inpatient Care	80% After Calendar Year Deductible (Benefit maximum the lessor of 30 days/calendar year and $10,000/lifetime)	60% After Calendar Year Deductible (Benefit maximum the lessor of 30 days/calendar year and $10,000/lifetime)	30 days in participating hospital ($500 copay each admission)
	Outpatient Care	80% After Calendar Year Deductible (Benefit maximum $1000/calendar	60% After Calendar Year Deductible (Benefit maximum $1000/calendar	$20 Copay (Maximum of 20 visits per calendar year)

Plan Features and Benefits		Indemnity Plan or Indemnity Plan in Preferred Provider Network	Indemnity Plan Out Of Preferred Provider Network	Health Maintenance Organization
		year)	year)	
Other Medical Services	Skilled Nursing Facility	80% After Calendar Year Deductible (30 days maximum per calendar year)	60% After Calendar Year Deductible (30 days maximum per calendar year)	100% Coverage (30 days maximum covered)
	Home Health Care	80% After Calendar Year Deductible	60% After Calendar Year Deductible	100% Coverage (60 days maximum covered)
	Hospice	80% After Calendar Year Deductible (6-month maximum)	60% After Calendar Year Deductible (6-month maximum)	100% Coverage (6-month maximum)
	Family Planning—Vasectomy	Not Covered	Not Covered	$100 Copay
	Family Planning—Tubal Ligation	Not Covered	Not Covered	$250 Copay
	Short Term Therapy	80% After Calendar Year Deductible	60% After Calendar Year Deductible	$20 Copay
Out-of-Pocket Limit		$1,000 Per Individual, $2,000 Per Family (in addition to calendar year deductible and copays)	$1,500 Per Individual, $3,000 Per Family (in addition to calendar year deductible and copays)	Individual—200% Annual Premium Family—200% Annual Premium
	Lifetime Maximum Benefit	$1,000,000 Per Individual	$1,000,000 Per Individual	

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